MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
PRESCRIPTION DRUG REPOSITORY PROGRAM

LONG TERM CARE RESIDENT DONATED DRUG OWNERSHIP RECORD

OPTIONAL INFORMATION FOR INSTITUTIONAL RESIDENTS: "FROM THIS DAY FORWARD I WISH TO DONATE ALL MY REMAINING UNUSED DRUGS, PURSUANT TO 19 CSR 20-50.020, TO A PARTICIPATING PHARMACY, HOSPITAL OR NONPROFIT CLINIC OF THE PRESCRIPTION DRUG REPOSITORY PROGRAM. I AUTHORIZE THE INSTITUTIONAL FACILITY IN WHICH I RESIDE TO MAKE THE DONATION ON MY BEHALF."

☐ **YES** ☐ **NO**

NAME OF INSTITUTIONAL FACILITY	ADDRESS OF INSTITUTIONAL FACILITY	
RESIDENT'S FULL NAME (PLEASE TYPE OR PRINT)	SIGNATURE OF RESIDENT	DATE

NAME OF REPOSITORY SITE	ADDRESS OF REPOSITORY SITE	TELEPHONE NUMBER

DONATED PRESCRIPTION DRUG INFORMATION

DRUG NAME	STRENGTH	MANUFACTURER	NDC (IF AVAILABLE)	LOT NUMBER	QUANTITY

DONOR INFORMATION

I certify that I own or represent the owner of the donated drug(s), that it (they) has (have) been stored according to manufacturer and/or USP requirements, and that I intend to voluntarily donate them to the Prescription Drug Repository Program.

NAME OF OWNER OF DRUG(S) (PRINT OR TYPE)	SIGNATURE OF OWNER OR REPRESENTATIVE
TITLE/RELATIONSHIP OF REPRESENTATIVE	DATE

I have inspected the donated drug(s) listed above and determined that they are safe and suitable for dispensing, the drug(s) and the packaging are in compliance with 19 CSR 20-50.025, and there are no controlled substances or drugs that require storage temperatures other than normal room temperature as specified by the manufacturer and/or USP.

SIGNATURE OF REPOSITORY SITE REPRESENTATIVE	DATE